University of Maryland
University Health Center

Health History Form

Name: _____ Date: _____
Home Address: _____ Dept: _____
Position: _____ Supervisor: _____ Home Phone: _____
Work Phone: _____ Work E-mail Address: _____ Date of birth: _____

Patient Information:

A. Sex: Male ☐ Female ☐ Transgendered ☐ Other ☐
B. Are you currently being treated by a doctor for any illness, injury, or other condition? Yes ☐ No ☐
C. Are you currently taking any prescription, non-prescription or herbal medications? Yes ☐ No ☐
   If yes, list medicines: _____
D. Are you currently under the care of a physician? Yes ☐ No ☐
   If yes, state why: _____
   _____
E. List any food, drug, or chemical allergies you have: _____
F. Hazardous agents or health risks in the work place: _____

Social History:

A. Do you have any hobbies or "side jobs" that require you to use chemicals, such as furniture stripping, sand blasting, insulation, lead, asbestos or other hazardous material(s)? Yes ☐ No ☐
   If so, please describe type of business or hobby, chemicals used, and length of exposure(s): _____
   _____
B. Habits: Do you:
   - Exercise regularly? Yes ☐ No ☐ How many times per week? _____
   - Use alcohol? Yes ☐ No ☐ How many times per week? _____
   - Smoke cigarettes? Yes ☐ No ☐ How many packs/day? _____for ____ years
   - Use illegal drugs? Yes ☐ No ☐ Explain: _____

Family History: Has anyone in your family ever had any of the following? (Include your parents, brothers and sisters, and children, if any.)

		Relationship			Relationship
A.	Heart disease?	Yes ☐ No ☐	D.	Cancer?	Yes ☐ No ☐
B.	Diabetes?	Yes ☐ No ☐	E.	Stroke?	Yes ☐ No ☐
C.	High BP?	Yes ☐ No ☐			

Medical History: Do you have any history of:

1.	Anemia	Yes ☐ No ☐	2.	Diabetes	Yes ☐ No ☐
3.	Asthma	Yes ☐ No ☐	4.	Emphysema	Yes ☐ No ☐
5.	Bleeding Problem	Yes ☐ No ☐	6.	Heart Attack	Yes ☐ No ☐
7.	Cancer	Yes ☐ No ☐	8.	Hepatitis	Yes ☐ No ☐
9.	Chronic Bronchitis	Yes ☐ No ☐	10.	Hernia	Yes ☐ No ☐

Medical History continued: Do you have any history of:

11. High Blood Pressure	Yes ☐ No ☐	12. Seizures	Yes ☐ No ☐
13. Kidney Disease	Yes ☐ No ☐	14. Stroke	Yes ☐ No ☐
15. Liver Disease	Yes ☐ No ☐	16. Tuberculosis	Yes ☐ No ☐
17. Pneumonia	Yes ☐ No ☐		

		Comments
18. Visual or hearing difficulty	Yes ☐ No ☐	_____
19. Shortness of breath or chronic cough	Yes ☐ No ☐	_____
20. Chest pain or fainting spells	Yes ☐ No ☐	_____
21. Irregular heart beat or murmur	Yes ☐ No ☐	_____
22. Vomiting blood, dark stools, or heartburn	Yes ☐ No ☐	_____
23. Urinary discomfort, bleeding, or frequency	Yes ☐ No ☐	_____
24. Back, neck, or joint pains	Yes ☐ No ☐	_____
25. Fractured bones or joint dislocation	Yes ☐ No ☐	_____
26. Unusual skin growths or rashes	Yes ☐ No ☐	_____
27. Headaches or dizziness	Yes ☐ No ☐	_____
28. Experience numbness or muscle weakness	Yes ☐ No ☐	_____
29. Gynecological problems	Yes ☐ No ☐	_____
30. Emotional problems	Yes ☐ No ☐	_____

31. List any other conditions not listed above: _____

_____

Tests and Immunizations: Please check box of those you have had and enter year

☐ Tetanus shot: _____ ☐ Rabies vaccination series: _____

☐ TB test: _____ ☐ Hepatitis B: _____

☐ Chest x-ray: _____ ☐ Influenza vaccine: _____

Occupational History: Do you know or have you ever worked with any of the following agents/hazards? If so, please check box and state when you last worked with the agent and how long.

☐ Asbestos _____ ☐ Exhaust _____

☐ Biological agents/hazards _____ ☐ Formaldehyde _____

(Type _____) ☐ Pesticides _____

☐ Excessive heat _____ ☐ Radioactive material _____

☐ Excessive noise _____ solvents (Type _____)

I understand that this physical examination is not designed, nor intended, to replace a regular physical examination, or routine medical care, by my private physician. I understand that this examination and all subsequent examinations are highly specific to evaluate my ability to perform certain tasks noted in my job description. This examination will not cover all aspects of a full physical examination.

Signature: _____ Date: _____